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Total Parenteral Nutrition Is Adapted to Home Use

By Sue Wymelenberg
Special Tribune Correspondent

One of Dr. Scribner's patients works in her kitchen while connected to a total parenteral nutrition system. The patient, who has severe scleroderma of the bowel, has had no oral food or fluid since February, 1974.

Total parenteral nutrition, the intravenous hyperalimentation technique being adopted increasingly by hospitals to feed seriously ill patients, is being successfully adapted to home use—much like kidney dialysis—for a number of disorders.

In Seattle, Dr. Belding Scribner, a nephrologist known for his pioneering work with the artificial kidney, reports very good results with 35 patients taught to feed themselves intravenously at his University of Washington training center. One of his patients has not had any oral feeding for four years.

In Boston, 10 patients from three hospitals are on total parenteral nutrition (TPN) at home, at a nursing home, or at a chronic facility.

Dr. George Blackburn, director of Nutritional Support Services at the New England Deaconess Hospital, is as convinced as Dr. Scribner of the efficacy of long-term parenteral nutrition outside the hospital.

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Budget Cuts Threaten Havoc In NYC Municipal Hospitals

By Michael Herring
Medical Tribune Staff

New York—With a number of resident physicians here already reporting avoidable complications and even deaths among municipal hospital patients as a result of the recent $57,000,000 cutback in Health and Hospitals Corporation funds—on top of an earlier $70,000,000 cut—the mayor's new plan for another $95,000,000 budget slash has caused many to doubt that the hospitals themselves can live through this unprecedented "medical emergency."

Dr. George Kaysen, Chief Resident in Medicine at the Abraham Jacobi unit of Bronx Municipal Hospital, told Medical Tribune that patients are already dying due to a shortage of nurses. "With one night nurse taking care of 30 patients in different rooms, it's not unusual to find patients dead in bed simply because a respirator has stopped working," he said. "People deplore capital punishment, but what do you call this? The only difference is that you don't know who it's going to be beforehand."

Nevertheless to cope with the $57,000,000 loss, the corporation's board

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Ex-Dean Concerned by Drift To Needless Total Workups

By Frances Goodnight
Medical Tribune Staff

Atlantic City, N.J.—A former medical school dean expressed concern here over what he views as an "unchecked drift" in teaching hospitals toward the all-inclusive and "sometimes obsessively complete" workup of patients.

"In an effort to be 'thorough' we often seem to substitute a grueling, somewhat mindless workup for one which is discriminating," Dr. David E. Rogers said in his presidential address to the Association of American Physicians.

Dr. Rogers, president of the Robert Wood Johnson Foundation and former dean at Johns Hopkins, called for

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Biometric Analysis of UGDP Study Fails to Allay Diabetes Controversy

By Harriet Page
Medical Tribune Staff

New York—The controversy over how to treat diabetes patients has not diminished with the recent report of the Biometric Society supporting the University Group Diabetes Program study of five years ago. That study claimed patients treated with the oral hypoglycemic agent tolbutamide showed an excess of cardiovascular mortality when compared with patients in other treatment groups.

In a series of telephone interviews, Medical Tribune found wide variations among clinicians. At one end of the spectrum, for example, is Dr. Holbrooke S. Seltzer of Dallas. He said he continues to regard tolbutamide "as the safest drug ever made," and said he does not believe the findings of the U.G.D.P. proved it otherwise. As for the Biometric Society report, Dr. Seltzer said, "they looked over old data, but they didn't add anything new." Dr. Seltzer is Professor of Internal Medicine at the University of Texas Southwest Medical School and chief of metabolism at the Dallas Veterans Administration Hospital.

At the other end of the spectrum, for

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making rounds at press time

NEW YORK M.D. SLOWDOWN continues despite opposition from hospital workers and some M.D.s, and refusal of politicians to consider further malpractice reforms. Local 1199 of National Union of Hospital and Health Care Employees want M.D.s to give recently-passed state joint insurance scheme a chance, have threatened to cut off services to patients of those leading job action.

CLOSET ALCOHOLICS may now be identifiable by a 34-question test developed at Mayo Clinic. The test can be taken by a patient, and is even more accurate when given to the patient's spouse, according to Drs. Robert Morse and Wendell Swenson.

Budget Cuts Threaten Havoc in NYC's Municipal Hospitals

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of directors has already adopted president John L. S. Holloman's proposals to close down 250-bed Francis Delafield Hospital, drastically reduce affiliation commitments and support to nursing schools, eliminate vacant positions, and reduce expenditures for equipment and supplies.

According to a MEDICAL TRIBUNE spot check of city hospitals, Dr. Holloman's proposals will also greatly reduce existing staff, facilities, and services in the remaining 18 hospitals, and drastically increase workloads.

'Impact Almost Incalculable'

When the additional $95,000,000 slash was announced, Dr. Holloman predicted that "a large number of hospitals," as well as Delafield, will also have to shut down. He also indicated that a number of emergency rooms would have to close.

"The impact," he said, "is almost incalculable."

A spokesman for the corporation exclaimed: "It's absolutely incredible. I don't know how the hell we're going to provide health care."

Before the new cut was revealed, Dr. Gerald Thomson, Director of Medicine at Harlem Hospital called the Holloman plan to save $57,000,000 "tragic and irresponsible. The future looks grim unless the corporation awakens to its responsibility as an advocate of the physical well-being of the patients in these hospitals rather than as an advocate for the fiscal solvency of the City of New York."

While many other physicians agree that the Health and Hospitals Corporation has been far too acquiescent in responding to the mayor's repeated demands for cutbacks—particularly in taking the $70,000,000 cut earlier this year—the corporation had, for a time at least, averted the original mayoral plan to close down three other hospitals along with Delafield. Yet with nowhere left to turn for savings, the corporation will almost surely lose those and other hospitals it has struggled to keep alive.

"I think the proposed cuts are horrible," Dr. Kaysen told MEDICAL TRIBUNE. "Loss of affiliation with accredited medical schools will mean that municipal hospitals will become 'snake pits' as professional expertise is withdrawn.

A Vicious Cycle

"The situation here is already such that anyone who leaves legitimately for any length of time has no job when they return. The proposal not to replace vacated positions will only create a vicious cycle. As fewer people work longer and harder, their chances of becoming sick or injured will increase. Then, if they are forced to leave, they lose their job and the remaining staff have an even greater workload.

"We've already had an instance here of a nurse who injured her knee after five years of service and had to be hospitalized. When she returned to work she was evicted from the building by security guards."

At 169-bed Sydenham Hospital in upper Manhattan, one of those that the mayor has suggested be closed, Dr. Manuel Acevedo, Senior Resident in Surgery, is already making plans to leave. "Even though Sydenham is still open for the time, since there is no accredited program in surgery or medicine—and certainly no plans to begin them now—I can't stay around. Without these teaching programs, many others will also be leaving here. Of course this will cause further deterioration in patient care."

Dr. Acevedo explained that Sydenham has never been affiliated because of a lack of funds, though plans were in the making to affiliate the surgical program before the current crisis. "The new situation here will probably consist of ward physicians hired on the basis of a 40-hour work week. These physicians, who have finished their training but have not got their licensure, will be in a 'visiting staff' category. This obviously not the best arrangement for a hospital that has already suffered from neglect and overcrowding for many years."

Board Members Criticized

Dr. Isa Goldman, Chief Resident in Medicine at 540-bed Coney Island Hospital in Brooklyn, added that "some members of the board of the Health and Hospitals Corporation are clearly irresponsible in going along with repeated budget cuts." Among others, he singled out Dr. Lowell Bellin, city Health Commissioner, as displaying a great lack of concern for the corporation.

"The municipal hospitals cannot provide quality care without the expertise that exists in the voluntary hospitals. Disaffiliation will virtually destroy the basic idea of equivalency of care for everyone."

Dr. Kaysen indicated that this idea is already fading: "In my first six months as Chief Resident at Jacobi, we didn't have enough nurses to handle more than 16 of the 20 beds in our coronary care unit. I know I have already sent patients to their death by having to refuse them, even though the beds were there.

"I remember the son of an 86-year-old woman begging me to admit her to the CCU. I could only say that the patients already there were in their 40s, while his mother was 86. 'But she's going to die if you don't let her in,' he said. 'I'm afraid you're right,' I said, 'but there's nothing I can do. We have the beds, but no one to attend them.' Of course the woman died."

Dr. Nayvin Gordon, a first-year resident in family practice at Kings County Hospital, told MEDICAL TRIBUNE: "The proposal to share services will only mean that patients will have to travel further to get care, and we will all be overworked and overcrowded.

"At Kings County, we have already had severe cuts in staff, including 75 nurses. Also, the radiation therapy building is being closed, and with this decaying structure that belongs in a museum, further cuts are going to make conditions unbearable."

The Holloman proposal to "share services" is nothing new and is already causing problems, Dr. Kaysen added. "There is a hemodialysis machine at Jacobi for emergencies," he said, "but no one has bothered to hire anyone to operate it. I know of a case of a 28-year-old man who suffered irreversible brain damage while being transferred to [Albert Einstein College Hospital] because he couldn't receive dialysis at Jacobi."

Big Strike Held Only Solution

According to Belmont Kindler, Executive Secretary of the Bronx County Medical Society, a large-scale strike action is the only solution to the problem. "The legislators, most of whom are lawyers, seem to be protecting their professional colleagues, rather than considering the health of the patients involved. But when anesthesiologists in California walked out and stayed out, these same legislators were begging them to come back. Doctors have to organize and unify if they are going to survive this," he said.

Dr. Richard Cooper, cardiology fellow at Morrisania Hospital in the Bronx also spoke of strike action and community pressure, as well as reforming the structure and financing of the system, and new legislation.

"We are planning a big conference in early June to decide the strategy for all the health organizations. The proposals handed to us are only going to create chaos in the entire system, as we continue to stretch everything thinner and thinner to take care of patients.

"The outcome of it all depends on how people respond to it. We can save our municipal hospitals if we fight hard enough, and I think people are waking up to the fact that if their hospital closes, there may not be anywhere else for them to go."

In the near future, Dr. Kaysen indicated, the time and place of a medical emergency will determine whether the patient lives or dies. "The situation is absolutely terrifying," he said. "If you get sick after midnight and there isn't a municipal hospital you can get to in time, you're as good as dead."

Not Receiving Hospitals

This is because volunteer and private hospitals are not designed or equipped to act as receiving hospitals, he said. Instead, they administratively select to run at 100 per cent capacity at all times. As soon as there are openings, these hospitals let private doctors know that patients may be admitted. Usually by 2:00 or 3:00 pm, Dr. Kaysen said, all the beds are spoken for.

"For example, if you're admitted to Morrisania with a heart attack after 3:00 pm, you're taken to the emergency room holding area, where a first-year medical intern is responsible for watching you, as well as taking care of anybody who comes into the emergency room, until a bed opens up in the hospital." The wait, he said, may take eight hours.

Dr. Jay Dobkin, senior resident in Medicine at Montefiore Hospital and Medical Center in the Bronx, a voluntary hospital, said, "There's no way, with our marginal operations, that cuts like this can give the appearance of anything but impending disaster. He pointed out the unusual situation that exists between North Central Bronx Municipal Hospital, Montefiore, and Morrisania.

"Right now, North Central is an unoccupied city hospital built by the state as a replacement for Morrisania. However, it's four miles from there and physically connected to Montefiore. What this hospital is doing here in the first place, instead of in the community it is supposed to serve, is a bit bizarre to begin with, and no one, not even Dr. Cherkasky the director, has been able to explain it to my satisfaction."

As it stands, he added, conditions at Montefiore are exemplified by the emergency room, which is still run out of two trailers attached outside the building as a temporary measure five years ago.

"We're working to organize opposition to these cuts and support for improved services," he said. "It's a very complex mess right now, but I wouldn't rule out direct action at all."

Basic Relationship Eroding

While it is easy to blame someone else for the fiscal crisis crippling this entire city—the mayor himself did so in his budget announcement—perhaps Dr. Thomson of Harlem summed up the responsibility of doctors when he said:

"What we are seeing here is the evolution of institutions. Once, doctors took care of their patients and patients related to their doctors. But now things are so complicated that most medical professionals work as agents for institutions and agencies, which stand between the individual doctor and the patient.

"Now we're facing a crisis in which politics and economics are largely determining the quality of our health care. It only shows us how far away we are from the kind of basic relationship we ought to have with our patients."

Hospital Costs Top 50% In Many Health Budgets

Medical Tribune World Service

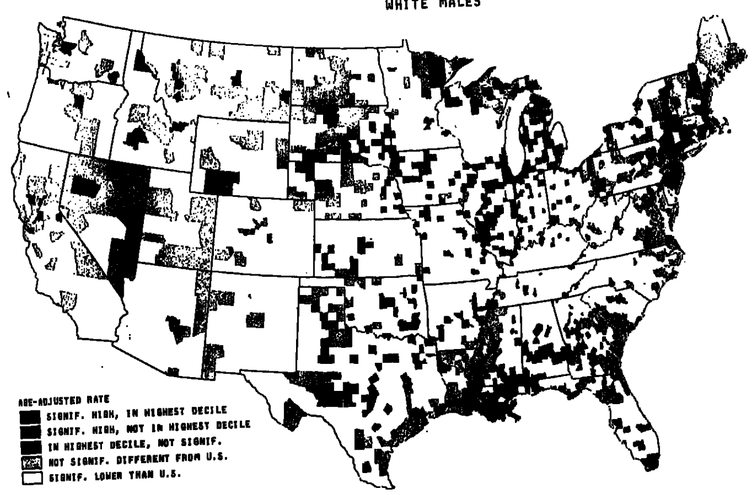
GENEVA—Hospital expenses exceeded half of the annual health budgets in most of 26 countries at different states of economic development surveyed by the World Health Organization.

In Northern Ireland, the cost of hospitals is 75 per cent of the budget, and in Denmark to more than 80 per cent, Dr. Halfdan Mahler, the W.H.O. director-general, reported in the organization's Fifth Report on the World Health Situation.

The total hospital expenditures are probably even higher, since the overall budgets of public hospitals in most countries may include expenses, covered from other than government sources, such as drugs, x-ray films, cleaning materials and non-perishable food from central stores. There is also at times an important contribution by private insurance funds.

Private insurance funds also contribute to operating expenses, especially in countries such as Switzerland where most of the hospital expenses are met by health insurance funds.

Survey by County Clarifies Cancer Mortality Pattern



One of the maps published by members of the National Cancer Institute showing cancer mortality by county. The highest rates were found in heavily industrialized areas, revealing certain strong cancer-industry associations.

Cancers, Industries Linked by Types

Medical Tribune Report

BETHESDA, MD.—A county-by-county survey of cancer mortality in the contiguous United States has revealed strong associations between certain types of cancer and various industries.

Preliminary results from the continuing study show that there are excess mortalities from bladder cancer in automobile manufacturing areas, from bladder, lung, and liver malignancies in chemical plant neighborhoods, and from lung cancer in the environs of copper, lead, and zinc smelters.

Five members of the National Cancer Institute's epidemiology branch are conducting the study, which is essentially a series of analyses of all cancer deaths throughout the country. The mortality data are collected from death certificates by the National Center for Health Statistics and turned over to N.C.I. in computer type form.

Pollution Association 'Evident'

The associations between various cancers and types of industry were found in an analysis of all cancer deaths among whites during the 20-year period from 1950 through 1969 in 3,056 of the 48 states' 3,066 counties (because of their small size, 10 counties were lumped with others).

"It seems evident that these associations are the result of industrial pollution," said Dr. Joseph F. Fraumeni, Jr., one of the investigators working on the study, during an interview.

Sixty-four of the counties had higher than usual bladder cancer mortalities, and the predominant industry in most of them was car making.

One hundred thirty-nine counties in which chemical plants are most concentrated had excess deaths from bladder, lung, and liver cancer, and in New Jersey, which has an unusually large chemical industry, every county ranked among the highest 10 per cent of the country's counties for bladder cancer.

That state's Salem County, where a quarter of the men work in chemical plants, had the highest bladder cancer mortality among all 3,056 counties. One chemical plant in the state had 330 cases of bladder cancer among its workers during the last half-century. "The company was quite aware of this, but they didn't tell anyone," said Dr. Robert Hoover, another of the five investigators.

Arsenic and Lung Cancer

A third team member, William J. Blot, Ph.D., said it seemed almost certain that the high lung cancer mortalities around the nation's smelters were due to arsenic exposure. He noted that levels of arsenic were high in men, women, and children living around the smelters, which emit the known carcinogen during the ore refining process.

In one of his earliest cancer epidemiology studies, Dr. Fraumeni found a threefold increase in deaths from respiratory system malignancies among 8,047 white male smelter workers exposed to arsenic between 1938 and 1963. The more the men were exposed to arsenic and sulfur dioxide, the higher their cancer mortality, and those who were heavily exposed and worked in smelters for more than 15 years had an eightfold excess death rate.

Industrial pollution did not hypothetically explain all the excess cancer mortalities the investigators found, however.

There was an unusual concentration of lung cancer deaths along the Gulf coast between New Orleans and Houston, an area without major automobile manufacturing, chemical processing, or smelting. Cervical cancer was particularly deadly in the Northeast and Appalachia, and the investigators thought it might be linked to poverty.

Some cancers appeared to be linked to climate—skin cancers caused more deaths in the generally sunnier southern part of the country, for instance.

In June the team will publish its geographic findings in colored map form. The *Atlas of United States Cancer Mortality by Counties, 1950-1969* will contain 66 maps of the 48 states showing cancer death gradients county by county, first as combined cancer maps by sex and then as maps showing 35 site cancers by sex.

Drs. Fraumeni, Hoover, and Blot and their two colleagues, Thomas J. Mason, Ph.D., and Frank W. McKay, the team's computer programmer, will add more recent cancer mortality information to their continuing analyses as it becomes available. They now have coded data about all 5.7 million recorded cancer deaths in the country from 1950 through 1971 as well as about 50 per cent of the deaths that occurred in 1972. Data for all 1973 and 1974 deaths should be available by November.

Study of Nonwhites Planned

One of the team's future analyses will be of geographic patterns of cancer in nonwhites, about whom the county-by-county mapping technique used to pinpoint cancer clusters in whites would be meaningless because they are generally more thinly spread around the country. Geographic cancer patterns among nonwhites will probably be shown by "state economic areas" (economically similar counties) within states, Dr. Fraument said.

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Rogers Concerned by Drift to Total Workups

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more emphasis in teaching services on the patient-oriented approach to problems rather than the problem-oriented approach to patients.

To achieve this, he advocates re-establishment of general internist consultants as highly visible members of the academic team—accomplished physicians "who are secure enough to pursue the most likely rather than the totality of diagnostic possibilities and who use therapeutic agents in a similarly restrained and discriminating manner."

A few such individuals play a vital balancing role in departments of medicine today, Dr. Rogers said, but he thinks more are needed to help modulate high-powered technology as it applies to patients.

Another step that he feels would be desirable is forceful reassertion of a philosophy "which views sins of commission as seriously as sins of omission." There should be, he contends, firmer application of ground rules holding that "overdiagnosis is bad and that each potentially hurtful procedure must be defended on the basis of its potential benefit to a particular patient."

Citing medical advances in recent years, Dr. Rogers pointed out that the physician's capacity to do good or harm to patients has been greatly extended by new diagnostic procedures and potent therapeutic agents.

Qualitatively New Problem

The quantitative changes in medical technology are now of such magnitude that the profession is faced with a qualitatively new problem today, he continued. The nature of the problem is different because of its proportions, in his view, and thus deserves serious attention.

Dr. Rogers stressed that his concern should not be interpreted as "an exhortation to return to 'the good old days,'" or the abandonment of the laboratory, or less intensity in scientific consideration of problems.

"It is rather a plea for more restraint coupled with more discrimination in the use of the powerful tools we now have at our command," he said. "It is a plea for more precise patient-benefit application of our interventions."

As an example of need for restraint, Dr. Rogers noted that it is not unusual to find an older patient—one who had been able to walk into the hospital—dehydrated, slightly confused, and somewhat the worse for wear on the third hospital day because of 48 hours spent in undergoing a "staggering series" of diagnostic studies.

The "relentless approach" to diagnosis, he said, can produce a number of side effects:

- It feeds the feeling that modern physicians "are cold or impersonal in their dealings with sick people."
- The combination of an all-inclusive workup and the management practices now commonly used contributes to the "worrisome incidence of iatrogenic disease."
- The multiphasic, all-inclusive workup escalates costs of hospital care,
- An intense focus on thoroughness of workup "has tended to encourage the increasing selection of subspecialty careers by those we train as students and house officers."

The possibility should be considered, Dr. Rogers cautioned, that care of patients and the teaching of future clinicians may be suffering from too broad an application of thoroughness at the expense of selectivity.

The problem stems to a significant degree from the way teaching centers have evolved and the way they have been staffed, he said. Although the "total immersion" in highly specialized facets of biomedical science required by the staff of clinical departments has benefitted both medicine and patients, the mandate and the funds that permitted the building of first-class departments "did not include the costs of maintaining a cadre of general internists" broadly concerned with patient management.

"In assembling the orchestra," he commented, "we minimized the need for an occasional conductor who knows quite a bit but not all there is to know about each of the instruments, but who knows the score and how the composition should be modulated."

Dr. Rogers emphasized that to restrain technology and thoroughness in nonregressive, noncontentious ways will be difficult. The claim of taking a selective approach could be used to excuse sloppy or incomplete attention to a patient's problem, he agreed, and restraint—if improperly applied—"could seriously retard biomedical science."

Possible Cause of Friction

A further hazard, in his view, could be that the issue of a discriminating workup might bring about friction between younger and older physicians or specialists and generalists.

But despite difficulties in balancing "our technology, our humanity, and our wisdom" in the care of patients, Dr. Rogers feels that renewed concern over sins of commission and the re-establishment of internist consultants in academe might improve present practices.

"Applying proper restraint to our technology and using it in a discriminating manner," he summed up, "would help demonstrate to our public that we have proper concerns about American medicine and that we are moving responsibly to improve the quality of its application."

Immune Adherence Assay Held Superior for Hepatitis A

Medical Tribune Report

ATLANTIC CITY, N.J.—An evaluation of the two new tests for identification of hepatitis A antibody that were developed earlier this year has established the clear superiority of the specific immune adherence (IA) assay, Dr. Saul Krugman, of the New York University School of Medicine, reported here.

"Accumulated data indicate that the IA test is more specific, more sensitive, and simpler to perform than the complement fixation [CF] test," Dr. Krugman told the annual meeting of the Association of American Physicians.

Both assays were developed by Maurice R. Hilleman, Ph.D., and co-workers of the Merck Institute for Therapeutic Research (MT, January 29, 1975). Liver extracts of marmosets infected with human hepatitis A virus were used as a source of antigen.

'An Important Milestone'

Dr. Krugman described the Hilleman group's achievement as "an important milestone" in hepatitis A virus research, and said the IA antibody assay should prove valuable to clinicians and investigators alike.

Specifically, he foresees the assay's usefulness for diagnosis of hepatitis A, epidemiologic investigations, identification of persons susceptible or immune, quantitative assays of human immune serum globulin, and identification of the virus by workers trying to propagate it in cell culture.

The new assays were evaluated on serial serum specimens that had been collected from 20 patients who had type A hepatitis five to 10 years ago, Dr. Krugman said. In 1967, his laboratory identified two types of hepatitis—MS-1, which was later shown to be hepatitis A; and MS-2 or type B—and the present study could be based on specimens stored in deep freeze.

All specimens obtained from the 20 patients before exposure to type A hepatitis showed no detectable IA antibody. However, this antibody was detectable in 80 per cent of the patients within the first two weeks after onset of clinical hepatitis, in all 20 during convalescence, and in all 20 for the five- to 10-year follow-up period.

The CF test was considerably less sensitive. Peak levels of CF antibody seen in sera collected during convalescence were much lower than the levels of IA antibody, and in two patients CF antibody could not be detected in specimens obtained after seven years.

Early Lung Cancer Screening Held Feasible

By JOHN F. HENAHAN
Special Tribune Correspondent

DENVER—"The time has come for the American Cancer Society and the National Cancer Institute to consider going beyond their present recommendations for antismoking clinics and other preventive measures and acknowledge for the first time that detection programs for picking up early lung cancer may really work," says Dr. Robert S. Fontana, Associate Professor of Internal Medicine at the Mayo Medical School.

In the four-year-old Mayo Lung Project, covering nearly 8,000 high-risk men over the age of 45 who smoked at least a pack of cigarettes a day, 52 previously unsuspected lung cancer cases were picked up at the time the subjects entered the program, he told the A.C.S.-N.C.I. National Conference on Advances in Cancer Management here.

"In addition, 15 new cancers were detected in subsequent rescreening of men which occurred after they had entered the program."

Dr. Fontana ascribed the success of the early detection program to a combination of sputum cytology, the fiberoptic bronchoscope, and x-ray diagnosis, coupled with health questionnaires taken from patients who come to the clinic with ailments other than lung cancer.

Those who qualify for the project are randomized into a close surveillance group rescreened every four months and a comparison group for whom annual follow-up screening is recommended, Dr. Fontana explained.

So far, Dr. Fontana reported, sputum cytology appears to be especially useful for detecting the early presence of cancer cells in the central portion of the lung, where they cannot be detected by x-rays. With the fiberoptic bronchoscope, the cancer cells can be localized and sampled prior to therapy, he said.

The operability rate for lung cancer detected early in the Mayo project, he said, has risen to about 70-75 per cent, compared with the usual rate of about 30 per cent. Early detection could lead to a five-year survival rate of about 40 per cent, compared with 8-10 per cent at present, he estimated.

EDITORIAL CAPSULES

. . . brief summaries of editorials or comments in current medical and scientific journals.

On White Coats

". . . I wished to present two patients with Graves's disease: [and] requested that white coats be worn by the students. . . . [Later] I received, from one of the students, a note that . . . included the following comment: 'I would like to see the evidence that wearing of white coats by students is of any benefit to patients—isn't your request more to satisfy your own ego?'

"The following is my reply: The relation between a physician and his patient is serious and purposeful, not social, casual or random. In this relation the patient unburdens himself or herself of a set of concerns regarding health matters and transfers them to the accepting physician. . . . The physician's dress should convey to even his most anxious patient a sense of seriousness of purpose that helps to provide reassurance and confidence that his or her complaints will be dealt with competently.

"True, the white coat is only a symbol of this attitude, but it has also the additional practical virtues of being identifiable, easily laundered, and more easily changed than street clothes if accidentally soiled. . . . it would be totally inappropriate, even ludicrous, if the physician were to wear a bathing suit, a tuxedo, garden working clothes or a football uniform, even if they were neat and clean. In my opinion, blue jeans, loud shirts without ties, and similar dress are equally inappropriate, especially when you are dealing with patients who are members of generations older than yours. Casual or slovenly dress is likely to convey, rightly or wrongly, casual or inattentive professional handling of their problem. Such a patient may respond in an inhibited manner, fail to volunteer information, refuse to carry out a recommended diagnostic or management program, fail to keep appointments, and be uncomfortable enough to seek help elsewhere. The rapport so anxiously sought for with your patient may be irretrievably lost. . . .

". . . In this context, I view the large classroom as an extension of my office or clinic for a limited period and for a specified purpose. . . .

"Thus, I believe it is a mark of disrespect to both the patient and the physician for students to dress inappropriately, to smoke in their presence, to eat or drink food during the presentation, to read the newspaper. . . .

". . . I do not think I am 'hung-up' on the issue of respect. In our society an individual is judged to be innocent of crime until proved guilty. Is it not equally correct that every person is entitled to the respect of his fellowman until his behavior proves otherwise? . . . Respect is one of the stabilizing virtues and a necessary ingredient in any satisfactory interpersonal relation, in which it must be mutual and based on trust. . ." *(Special article, Joseph P. Kriss, M.D., N. Engl. J. M. 292:1024, May 8, 1975)*

IN CONSULTATION

What's New and Important in Multiple Sclerosis (MS)?

The Consultant

DR. GEORGE A. SCHUMACHER

Professor of Neurology, Department of Neurology, DeGoesbriand Unit, University of Vermont Medical Center Hospital, Burlington, Vt.; Member, Medical Advisory Board, National Multiple Sclerosis Society, New York

NEW DEVELOPMENTS may be divided among several areas of interest:

(1) *Etiology and Pathogenesis:* Increasing numbers of reports cite findings derived from immunologic (serologic and cellular) investigations supporting the possible role of viral or auto-immune tissue damage to CNS white matter. One theory holds that the latter ultimately develops after early life viral infection which remains long latent. Elevation of CSF and serum antibody titers to different viruses has been shown in MS patients (including measles, herpes simplex, varicella, vaccinia, and others), suggesting that a variety of viral agents could be *exogenous* nonspecific inciting factors and antigenic sharing with myelin protein or a specific kind of inherited immunologic aberration operating as the *endogenous* cause.

Intracellular nucleocapsids and fuzzy tubules, possibly representing viral aggregates, have been described in EM studies of MS lesions. Para-influenza virus allegedly grown from fresh MS brain (by tissue co-culture technique) and a CNS disease transmitted to sheep from human MS brain tissue have led to no conclusions of etiologic significance as yet. Specific immunologic reactivity has been shown by the finding of a higher incidence of genetically determined specific HL-A serologic and LD (lymphocyte-defined determinant) immune cell types in MS subjects than in the general population.

Defective Myelin Composition?

Epidemiologic studies of geographic distribution with comparisons of prevalence in migrant and native populations also support the hypothesis of probable exposure to some viral agent at about the age of 15 followed by a long latency period. Biochemical studies have indicated a reduction in polyunsaturated fats in affected brain tissue and a lower than normal level of the polyunsaturated linoleic fatty acid in the serum of MS patients, raising the question of defective myelin composition.

(2) *Diagnosis:* The strong support rendered to the diagnosis by the presence of a higher than average level of gamma globulin in the CSF has been superseded now by the even more significant finding of the "oligoclonal characteristic" of the raised IgG, consisting of several separate fractions or bands demonstrated by electrophoresis.

A hopeful new development in laboratory diagnosis is the application of the EMI brain scanner (computerized tomography) to the head with the capacity for demonstrating the discrete lesions or plaques of MS; it is not useful, however, in demonstrating brain stem or cord lesions.

(3) *Specific Therapy:* Benefit to the specific disease process from any treatment remains yet to be proved, and an adequately controlled, long-term trial of therapy has neither been designed nor put into effect which would permit sound conclusions.

Reports of favorable results of therapy based on hypothetical causes remain to be substantiated. These include a low animal-fat diet, high polyunsaturated fat intake, especially sunflower seed oil with a high proportion of linoleic acid, and a gluten-free diet (eliminating wheat, rye, barley, and oats). The alleged reduction in frequency of relapses has not been shown to be due to the regimens and none have been shown to alter the long-term downhill course of the disease.

ACTH and adrenal steroids remain in wide usage with convictions of benefit but without proof of value. Immunosuppressants (to *suppress* lymphocyte mediated hypersensitivity), antilymphocyte globulin, and basic myelin protein desensitization have not shown adequate evidence of benefit. An opposite approach to therapy, using transfer factor to *stimulate* lymphocytes, based on a theory of causation owing to immunologic incompetence in MS, remains highly experimental. The annual flow of reports of allegedly effective but ill-founded, new (or revived) therapies continue, often announced by the scientifically uncritical lay press or other media and seized upon by a small minority of suggestible patients who then create waves of unjustified enthusiasm through personal testimonials, until the newly heralded treatments die out of their own accord.

(4) *Symptomatic Therapy:* The new orally administered striated muscle paralysant, dantrolene sodium, has been strongly promoted by the manufacturer as an effective agent in reducing spasticity, reflex spasms, and involuntary clonus in the lower limbs, but seems useful in only a proportion of patients, mainly bed or wheelchair ridden, because of the costly trade-off of giving up muscle strength and because of a moderately high incidence of unpleasant side effects.

The alleged reduction in spasticity and pain in the lower limbs from the surgical implantation of an electrode on the upper spinal cord, self-activated by a radio-frequency transmitter in the patient's pocket, remains under study without as yet strong promise for ultimate usefulness. Electric bladder stimulators requiring electrodes implanted in the bladder wall have been reported as useful in training bladders to develop control in other neurologic disorders, but their value in multiple sclerosis remains to be demonstrated.

To what major areas should the therapy of multiple sclerosis be directed?

A consensus holds that no mode of therapy to date for the specific disease process itself is of proven value. A variety of approaches has become virtually obsolete, such as vasodilators, anticoagulants, histamine, vitamins, metabolic stimulants, hormones, antibiotics, natural food diets, Russian vaccine, anti-allergic therapy, and others. More recently proposed specific remedies remain unsubstantiated, including various diets (low fat, gluten-free linoleate), ACTH, adrenal cortical steroids (including intrathecal), immunosuppressants, antilymphocyte globulin, and others.

Numerous patients do not respond to any of these. Reported changes for the better are thought by many to be coincidental rather than owing to therapeutic effect. On the other hand, that some patients may benefit from one or another of these methods has not been disproved.

Therapy, therefore, is chiefly symptomatic and directed to motor dysfunction (weakness, spasticity, incoordination, daily acts of living), ocular disturbance, bladder and bowel impairment, pain, and to emotional and mood disorders.

Complications, chiefly genito-urinary and respiratory tract infections, and, more rarely these days, decubiti, must also be dealt with, usually in later stages.

What are the indications and results of treatment with adrenocortical steroids or ACTH?

Many physicians still utilize these agents during acute episodes with the hope of shortening attacks or preventing permanent irreversible dysfunction, but also administer them chronically over extended periods with the hope of preventing progression.

Among the large number of reports in the literature, many are poorly controlled and their conclusions unjustified. Among controlled trials of therapy, as many report lack of benefit as improvement, but the validity of even these studies remains uncertain.

What are some of the more recent procedures to relieve disturbing symptoms?

There are relatively few recent advances in symptomatic therapy. For motor handicaps, various modalities of physical therapy may be effective, including resistance exercises to improve strength, stretching to counteract muscle spasticity and contracture, gait training, utilization of appropriate gait aids, prosthetic devices (leg and back braces). Diplopia is relieved by patching one or the other eye alternately.

Field Tracheotomy Kit

An emergency field tracheotomy kit, including a pocket-size cutting device, designed by a group of Purdue students, was one of the ideas presented at Armco Steel Corporation's 10th annual design program. The theme: "Emergency Lifesaving Equipment." No awards are given, but the students have a chance to have work evaluated by experts.

For infrequent pain, often neuralgic in character, diphenylhydantoin or carbamazepine are effective.

For mood disturbances, emotional support, common sense psychotherapy, and the anti-anxiety and anti-depressant agents, diazepam and amitriptyline are useful.

Regimens to counteract constipation may be needed. The opposite, rectal incontinence, like urinary incontinence, is treated with anti-cholinergic agents, namely, atropine SO_4 or propanthelline. For severe muscle spasticity associated with flexor spasms, leading potentially to ultimate postural deformity from contracture, and for involuntary clonus, diazepam provides moderate but unpredictable help. A newer agent, dantrolene sodium, may provide even greater but also unpredictable benefit.

Self-stimulation by the patient with an electrode surgically implanted in the upper spinal canal is alleged to have helped some patients gain relief from pain and to improve motor control and sensation.

What is the recommended approach to patients with bladder dysfunction and incontinence?

The type of bladder dysfunction in multiple sclerosis varies depending on the site of the lesion. In upper cord lesions with spastic paraparesis, the problem is usually one of a small capacity hyperactive, frequently contracting bladder with urgency, frequency, and ultimately incontinence from inability to inhibit reflex detrusor activity, but also retentive in the form of difficulty in initiating micturition and usually in complete emptying.

In early stages the anticholinergic drugs, atropine or propantheline, diminish urgency, frequency, and incon

Continued on page

Doctors' Debate

MEDICAL TRIBUNE frequently receives extensive and well-documented communications from physicians on current subjects of controversy or those of great current medical interest. We invite contributions in these areas for presentation in this new feature.

Patients Should Buy Malpractice Insurance

The solution to the problem of malpractice insurance is as easily solved as the nose on all our faces. That is to merely have the patient buy their own insurance.

This is the same opportunity that an individual has when he decided to fly on an airlines or to own and drive his own automobile. They purchase their own insurance according to their state laws protecting themselves against possible injury. This has become particularly true since the public has become so law suit conscious and knows every doctor carries an insurance policy; surely every attorney knows this too.

The public, population or number wise, is a much larger segment than the number of physicians. If the public feels they will be maligned or have an untoward reaction to any medical procedure, then the risk would be covered by this new risk type insurance. If a state-run insurance company was set up —say $2.00 per person gathered yearly —with over 20,000,000 participating (California), you could see what a fund could be developed. Eventually a ceiling would be reached where no assessment would be made some years—and let the patient and the lawyer have at it.

Rates Would Depend on Risks

It is ridiculous and horrendous even to think of passing on 200 to 500 per cent increases to the patient due to present increases in premiums. I am sure insurance companies would set up actuarial studies for specific rates depending on the medical risks involved —i.e., the danger of an appendectomy or surgery or of a certain pill or medicine, etc.

Since every human mind and body is different only God can possibly know what kind of result will occur from any medical modality or procedure. No one can guarantee a result in medicine because of these inherent differences.

The doctor constantly deals only with percentages. Hence medicine is not an exact science because not every human being is exactly alike. Therefore, the patient must also weigh the risk or the advantage of seeing the doctor.

As you can see, the patient must also be responsible as well as the physician when he decides to drive his body to the doctor's office. Without this doctor-risk insurance, the individual could not sue at all since the insurance would be available to everyone. No insurance, no coverage. Just as the public has hospitalization insurance, auto insurance, airline crash insurance. This insurance would be run by the state government who would collect the assessment at state tax time.

Any other method of present insurance adjustment would be untenable. This is a simple common sense solution. The scheme would work if the entire populace has to pay for the insurance. However, I feel: someone is always responsible, whether it be the patient, the lawyer or the physician, and so the reasoning behind the airline, car-owning-driving individual type insurance which is available to everyone.

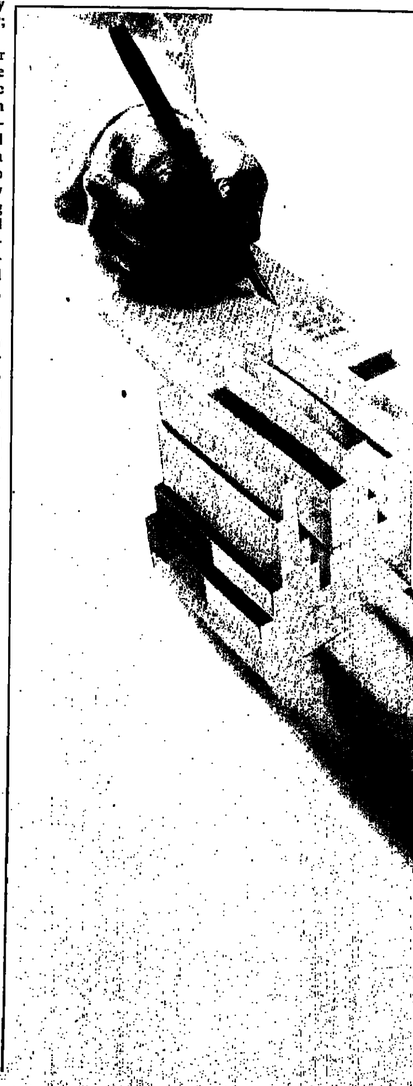
This, I feel, is a specific solution and the state could call a special moratorium and suspend law suits at this time until the program could be implemented. The same procedure that is used in other stalemate situations could be followed but at least the patients could get their necessary medical care.

For lack of embarrassment to either medical profession or political parties involved, you may use my name to this type of law and call it the Yarolin Bill or the Doctor Risk insurance bill, whatever.

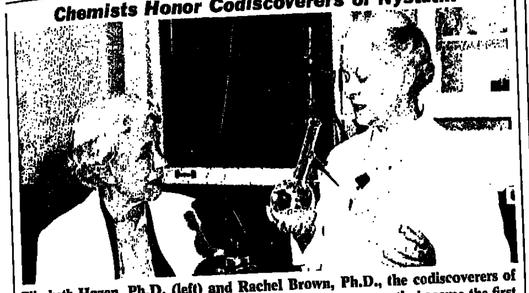
I would be glad to sit down at my office on designated days and work out any particulars with any doctors or tistics available as to mortality, morbidity etc. These are already available to insurance companies. In the past the old situation has only driven costs up by causing doctors to practice defensive medicine—run extra tests, extra x-rays to cover himself against suits.

I am sending this letter to the various government, medical and news agencies with the hope that this will allow greater freedom for both patient and physician and keep costs down in these inflating times.

EDWARD J. YAROLIN, M.D.
Santa Clara, California



Chemists Honor Codiscoverers of Nystatin



Elizabeth Hazen, Ph.D. (left) and Rachel Brown, Ph.D., the codiscoverers of one of the world's first antibiotics for fungal diseases, recently became the first women to receive the American Institute of Chemists' Chemical Pioneer Award. Here they examine early samples of nystatin, which they discovered while working for New York State Department of Health in 1949.

IN CONSULTATION

Continued from page 7

tinence by allowing a larger volume of bladder filling before bladder contraction. Lesions low in the sacral cord interfering with the segmental reflex arcs for bladder contraction are more apt to result in a large capacity, inactive, distended bladder, with absence of urgency and frequency but retention and ultimately overflow incontinence. The parasympathomimetic drug, bethanechol chloride, regularly administered may stimulate contraction and facilitate voluntary urination.

Strategic scheduling of liquid intake and regular timing of attempts at bladder evacuation are important. In later stages of bladder dysfunction, impaired voluntary control may no longer be amenable to drug therapy. In time the patient becomes more susceptible to urinary tract infection because of stasis, leading to the need for periodic cultures and appropriate antibacterial therapy. However, long-term prophylaxis with antibiotics is not recommended. Rather, increased fluid intake (assuming a satisfactory means of evacuation), daily intake of cranberry juice to maintain urine acidity, and chemotherapeutic agents (methenamine and nitrofurantoin compounds) are preferred as continuing preventive measures.

If bladder control is virtually lost, resort must be had to some form of artificial drainage. Either an indwelling catheter is kept indefinitely in place utilizing antiseptic precautions at the urethral meatus, or the more recently proposed repeated daily catheterizations by the patient or an attendant with meticulous antiseptic precautions are carried out.

Finally, newer surgical urinary diversion techniques provide perhaps the greatest convenience, least social handicap, and least risk of infection. An example is the ileal conduit, bypassing the bladder and functioning on the same principle as a colostomy. In addition to cystometrogram, cystoscopy, and radiologic visualization of the kidney and bladder, newer and more sophisticated techniques for evaluating function are available in some urology departments, assisting in decisions regarding the best method of management.

What recommendations would you make for a protocol to be followed in judging the efficacy of a new drug in the treatment of multiple sclerosis?

This is a complex matter about which there is no unanimity of opinion. Arriving at a reliable conclusion regarding the efficacy of any treatment modality for the specific disease process remains a difficult and unsolved problem. For a discussion of the difficulties involved, the reader is referred to the following papers: (1) *Am. Ann. N.Y. Acad. Sci.* 122:552, 1965; (2) *J.A.M.A.* 196:729, 1966; and (3) *Neurology* 24:1010, 1974.

Next In Consultation

DR. LARRY WATERBURY, Head, Hematology Section, Baltimore City Hospitals, Baltimore, Md. . . . will discuss new developments in hematology, including the use of bone marrow transplantation in severe aplastic anemia, and various aspects of pure red cell aplasia.

Car Deaths Drop 22%

Medical Tribune Report

WASHINGTON—Death rates for heart disease, stroke, and accidents declined in 1974, according to H.E.W. but cancer deaths rose. Deaths from motor vehicle accidents dropped 22 per cent as a result of lower speed limits.

The Only Independent Weekly Medical Newspaper in the U.S.

Medical Tribune
and Medical News
Published by Medical Tribune, Inc.

Science-Based Interventionist Medicine

IN HIS presidential address to the Association of American Physicians (see page 1) Dr. David E. Rogers referred to "the majestic march of science-based interventionist medicine." And, indeed, it has been majestic, almost awesome in its range of diagnostic techniques and in its therapeutic modalities, medical and surgical.

But Dr. Rogers, one-time professor of medicine, later dean of the Johns Hopkins University School of Medicine, now president of the prepotent Robert Wood Johnson Foundation, was not delivering an encomium on the accomplishments of "science-based interventionist medicine," for it needs none. He was turning a jaundiced eye on some of the *applications* or, rather, *misapplications* of its "vast array of intricate diagnostic procedures with which to determine what has gone astray" and on its range of therapeutic measures. And his target, primarily, was the "technologically thorough, sometimes obsessively complete workup of our patients in our teaching hospitals."

Dr. Rogers' point was that the gradual, quantitative changes in our diagnostic armamentarium have finally brought about a *qualitatively* new dimension—a new order of magnitude, as it were—to the size and character of the diagnostic workups in our teaching centers. He attributed this to the influence of the skilled subspecialists who stimulate workups "which seem instantaneously directed to all of the diagnostic possibilities" they can suggest, rather than workups consisting of "considered and sharply restrained series of studies directed toward the most likely or the most treatable." He bemoaned the substitution of the "grueling, somewhat mindless workup for one which is discriminating." He then added, "I think we have pursued the technologic imperative to do all that we are trained to do too far."

One of the aspects of this problem that he did not touch upon is a development of the past several years in many, if not all, of our teaching centers. As part of the "educational process" of developing responsibility, the house staff now reigns supreme, more or less (and mostly more rather than less) in decisions about diagnostic workups and therapeutic choices, even with private patients, unless the attending physician turns to the chief of the service to alter the house staff's decision. So, coupled with the subspecialists' suggestions is the house staff's ability promptly to bring them into being.

Dr. Rogers urges a discriminating selectivity in diagnostic workups and the forceful reassertion of "a philosophy which views sins of commission as seriously as sins of omission." Hear, hear!

Gram-Negative Septicemia

IN THE PAST several years problems in the manufacture of intravenous infusion systems led to contamination of the fluid with organisms that were predominantly members of the tribe Klebsiella – *Klebsiella, Enterobacter* and *Serratia*. Curiosity about these events led Drs. Dennis G. Maki and William T. Martin of the Center for Disease Control to a study of 5 per cent dextrose in water and in saline, the most frequently used infusion products in U.S. hospitals, to see whether there was a selective ability for the tribe Klebsiella to proliferate in glucose-containing intravenous fluids at room temperature.

This, in fact, turned out to be the case. In their discussion, these investigators note that most contamination of infusion fluid is probably extrinsic, introduced from without "most frequently during manipulation of the apparatus by personnel or by the patient." They also observe that "members of the tribe Klebsiella have been demonstrated in high frequency on the hands of both hospital personnel and patients."

Maki and Martin warn that the "data indicate that intravenous infusions suffer a significant risk of in-use contamination, frequently by tribe Klebsiella organisms that by their unique growth properties pose an increased hazard." Not only the cannula is a source of nosocomial sepsis –as has been noted in repeated studies–but so is the infusion fluid itself. They stress that at least every 24 hours "all bottles and delivery apparatus be changed," and that at each change of cannula all equipment be totally replaced.

They also mention that others have attributed a rise in nosocomial septicemias caused by members of the tribe Klebsiella to "increasingly heavy antimicrobial pressure selecting for multiply resistant pathogens." They suggest instead that the trend has been associated with increasingly heavy use of intravenous fluid therapy and, possibly, extrinsic contamination of the fluid.

Excess Vitamin D and Atherosclerosis

CLINICAL QUOTE: *"A tissue vitamin D level in swine fed a high fat, moderate cholesterol diet that is comparable to the assayed tissue vitamin D level of man increased the percentage of degenerative smooth muscle cells in the aorta of such swine in comparison with fat, cholesterol, and extra vitamin D unsupplemented swine."* (Dr. Fred A. Kummerow *et al.*, see page 21.)

"Let's just say you've reached the age of anxiety and antacid."

LETTERS TO TRIBUNE

Clinical Trial of Vitamin C

At Incline Village, Nev., I have prescribed massive doses of synthetic Vitamin C in water to over 2,000 acutely ill patients over an almost three-year period.

I have been very guarded about prescribing maintenance doses. Primarily Vitamin C has been used in doses of 15 to 30 to 60 grams a day for acute viral diseases. These diseases have included not only the common cold but influenzas, infectious hepatitis, viral pneumonia, mononucleosis, rubella, mumps, chicken pox, herpes zoster, and herpes simplex.

Tolerance in Ill

A remarkable increase in tolerance to Vitamin C in ill patients has been observed. Roughly 80% of well patients will tolerate about 12 to 16 grams a day in divided doses before diarrhea is produced. These same patients will easily tolerate 30 to 60 grams a day divided in 4 to 6 gram and sometimes 8 to 12 gram doses when acutely ill. Only then does the Vitamin C always produce diarrhea. This dramatic difference in the same patient required to produce diarrhea strongly suggests an increased absorption with viral diseases for some reason.

Approximately 20% of patients do not tolerate Vitamin C in these doses well. They may not like the taste, have much flatus, or have diarrhea at low doses. The rare patient having epigastric distress usually has known peptic disease. None of these problems have been serious and cease immediately on lowering or stopping the medication. Even most of these patients become more tolerant when very ill. The diarrhea produces no significant problem and is usually almost painless. Although urine is made acid, dysuria is not produced in these doses. There has been no case of urinary stone. Occasionally moderate doses will produce constipation. There have been no true allergic reactions to the pure synthetic powder although the natural tablets have been suspected on rare occasions. There has been no "withdrawal scurvy" with these massive doses used for short periods. No complications related to pregnancy have yet been observed.

'Bowel Tolerance' Level

It is my opinion that there is considerable beneficial effect but final proof of this benefit must await double blind tests. Several points should be made however. Patients regularly report a feeling of improvement just as "bowel tolerance" doses are reached. There seems to be less recurrence of symptoms when these doses are maintained for a day or so. Lesser doses often permit recurrence of symptoms if not maintained for a time approaching the usual uncomplicated course of the disease. As described in other studies, morbidity may be reduced. However, producing the maximum benefits thought to be obtained requires considerable physician management. All of the usually indicated medications are used.

Vitamin C may reduce the incidence of viral diseases but does not absolutely prevent them even in high doses. Responding to early symptoms with massive doses appears possibly most effective. The wisdom of long run high maintenance doses should be decided by long follow-up.

The doses of Vitamin C as described have been ingested for short periods of time by large numbers of patients without any serious difficulties. Problems were minor and rapidly reversed when the medication was decreased or stopped. Almost all problems were related to gastro-intestinal tolerance. On the basis of the clinical experience with large numbers of patients, it is thought that benefits of Vitamin C are maximum only at these high doses. Smaller amounts may prove helpful but are not as suggestive.

Mechanisms of action not ordinarily considered in nutrition should be sought.

ROBERT F. CATHCART, M.D.
Orthopedic Surgeon
Incline Village, Nev.

Total Parenteral Nutrition Is Adapted to Home Use

Continued from page 1

One of his patients is a 30-year-old with Crohn's disease, who has had all but seven feet of his bowel resected. The patient, who can obtain only partial nutrition orally on a liquid-free diet, has responded so successfully with using the "artificial gut" at home that he has gained 30 lbs. and has been able to go back to college. Two more patients are ready to go home, having finished their training in the technique.

DR. SCRIBNER

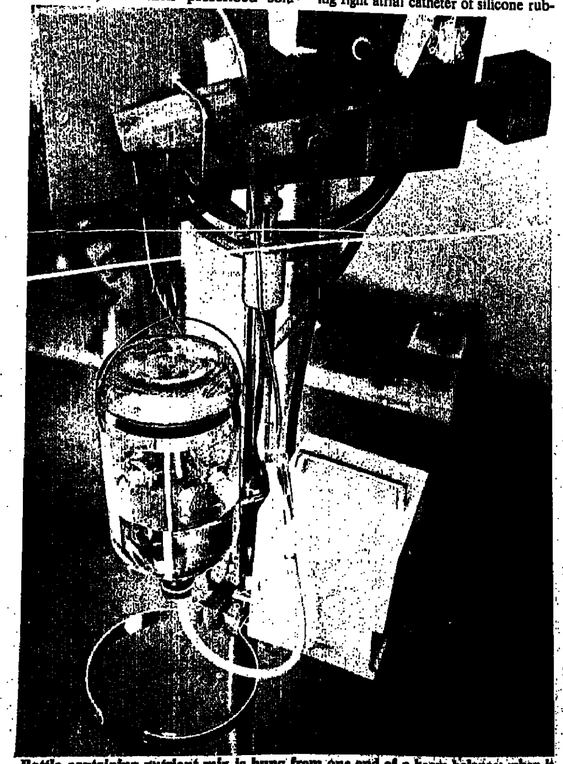
Although total parenteral nutrition is utilized most frequently by hospitals to meet the protein needs of patients debilitated by long term illness or major surgery, Drs. Scribner and Blackburn also view TPN as the major therapy for patients who are "gastrointestinal cripples."

These patients, they said, principally include those with various short bowel syndromes and Crohn's disease. Other patients have included one with dumping syndrome and Mast cell involvement, a patient with ovarian cancer, a patient with recurrent diverticulitis, one with acrodermatitis enteropathica, and one with sclerodoma of the bowel.

These patients take care of their catheters, mix their prescribed solutions, and connect themselves to a compact electric pump every night. Since the average daily intake ranges between 1,500 and 2,000 ml., the intravenous feeding usually takes 12 to 14 hours to complete, and is normally done overnight while the patient sleeps or relaxes.

Patients mix their own nutrients, adding nitrogen component, electrolytes, and vitamins from commercial preparations.

Dr. Scribner describes the home hyperalimentation system as consisting of four basic components: an indwelling right atrial catheter of silicone rubber, sterile nutrients bottled so they can be mixed safely by the patient just before infusion, the portable pump which controls the rate of infusion, and a portable stand rigged with a monitor that warns the patient when the bottle is almost empty.



Bottle containing nutrient mix is hung from one end of a beam balance; when it is almost empty the beam sets off an alarm, alerting the patient.

Catheter With Dacron Cuff

The catheter is implanted so it exists at the front of the chest where its external portion is fitted with a capped connector. It is equipped with a Dacron cuff about halfway down its length. In two or three weeks the cuff becomes ingrown with tissue, firmly affixing the tube to the subcutaneous tunnel. The cuff also acts as a mechanical barrier to bacteria ascending the tube exterior.

Clotting in the catheter has been prevented with a good degree of success by injecting it with heparin after each infusion and clamping it shut during the heparin injection.

The silastic catheter used under these conditions has enabled circulatory access to be maintained with a low rate of complications, Dr. Scribner told MEDICAL TRIBUNE.

The basic nutrient for each patient is packaged in a two-liter bottle containing 1000 ml. of a 60 per cent dextrose solution. The vacuum in the half-empty bottle enables the patient to add to it the nitrogen component—via a solution series set—and other additives, such as concentrated electrolytes and vitamins.

This mixture is administered by a portable Holter pump. Its small size and ability to run on a battery for several hours gives the patient considerable freedom of movement, Dr. Scribner said.

The bottle is hung from one end of a beam balance; when it is almost empty the beam sets off an alarm, awakening or alerting the patient so he or she can slow the infusion rate for the last 30-45 minutes, averting the possibility of the reactive hypoglycemia sometimes caused when a fast glucose infusion is abruptly stopped.

Four years ago this patient was bedridden. Now she can ride daily.

Equipment Cost $1,000

Cost of this equipment, including a spare pump, is about $1,000; solutions and supplies for infusing on a nightly basis are another $700 a month. Nutrient supplies are delivered by the patient's local pharmacy every three months.

Patients from all over the United States have been referred to Seattle's University Hospital for training in the artificial gut techniques.

Dr. Scribner explained that they are accepted into the program if they had developed or were expected to develop severe malnutrition due to an inability to digest nutrients orally, if other forms of therapy had failed, and if it appeared they would benefit from TPN.

In the training program they are taught general sterile technique and the principles of parenteral nutrition, including the recognition of abnormal signs and symptoms. Dr. Scribner noted that patients are made well aware of the possible complications or have experienced them during training, and the most typical complications have not occurred when the patients were at home.

Besides infection, complications that can occur are acute hepatic enlargement, generally when the infusion is too rapid; acute glucose intoxication; and severe insulin reaction associated with sudden stoppage of infusion.

During the final stages of training, the patient lives at a nearby motel so he or she can carry out the procedure as it would be done at home. This helps put a final polish on the technique, Dr. Scribner said, and encourages a feeling of confidence, an important factor when patients live at some distance from the training center.

At home, TPN patients are followed by their own physician and their regular laboratory tests are made at the local hospital.

Only one patient in Dr. Scribner's 35 has died from complications attributed to the artificial gut system. He died of staphylococcal septicemia subsequent to a clotted and badly infected shunt. This patient, the first in the program, began treatment before the right atrial catheter technique was developed. The large Thomas femoral artery-to-vein Silastic shunt had been used and had thrombosed.

In the patients with Crohn's disease, Dr. Scribner said, the outcome of the use of home TPN has depended largely on the severity of the intestinal damage and how long the patient has been debilitated. Patients treated before they have permanent gut damage, he said, have become "completely rehabilitated"—gaining weight, exercising, becoming symptom-free, and able to live a fairly normal life—though not necessarily eating food. About one-forth of his patients have been able to resume oral feeding.

All of the patients with short bowel syndromes have been able to reach and maintain good nutritional status on home TPN, he said. They are free of GI symptoms and have returned to a normal life style.

In the program's total experience with the artificial gut approach, systemic infections have occurred once for every three patient-years of catheter use. Since the first death, all have responded quickly to catheter removal and antibiotics, and nutrition was not interrupted for more than two weeks. Some have been cured without pulling the catheter.

There have been three cases of thromboembolism; however, only one could be attributed to the catheter.

"Most striking has been the improvement in strength and endurance of all the patients," Dr. Scribner said. "Early weight gain at first appears to be fat, but as therapy continues, muscles develop."

Patients are able to be weaned from high doses of narcotics, are able to exercise, and some have returned to work or school, he noted. In Crohn's disease, their need for large doses of steroids and immunosuppressive drugs also has been greatly reduced.

'Dramatic' In Regional Enteritis

"Using the artificial gut to permit complete rest of the bowel in patients with severe regional enteritis usually has a very dramatic effect," the Washington nephrologist reported. "Fistulae often heal spontaneously and local peritonitis subsides, localizes, or is cured."

Although using the artificial gut is expensive, it appears less so when compared to the cost of hospitalizing these patients for the months and years usually required, Dr. Scribner said.

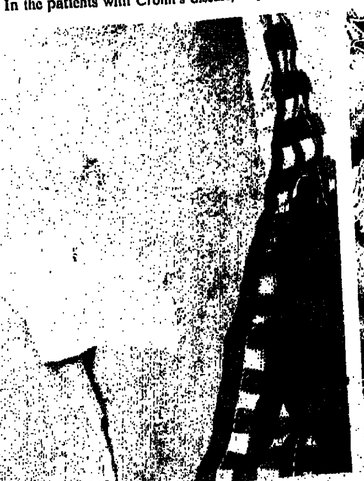
As additional years of experience are gained with TPN, he and others are beginning to see the first signs of copper and zinc trace metal deficiency, which has been satisfactorily remedied so far by adding one mg. of copper alone to the diet.

Acute fatty acid deficiency also has occurred and has been reversed by including it in the feeding.

In the training program, patients are taught general sterile techniques and caring for equipment, as well as how to recognize abnormal clinical signs and symptoms.

Basic nutrient is packaged in a 2-L. bottle containing 1,000 ml. of a 60 per cent dextrose solution. Patient puts in nitrogen component, electrolytes, vitamins.

The atrial catheter is implanted so that it exits at the front of the chest. The external section is fitted with a capped connector.



The catheter with the patient connected to the Holter pump and nutrition infusion under way.

We know Librium works.
(chlordiazepoxide HCl)

We're still learning more about how and why.

Value of continuing animal research

Clinical knowledge of Librium is extensive, yet its mode of action remains under continuing study. Data from animal experiments have been presented here for their intrinsic interest and because such findings often provide direction to new research, both experimental and clinical. *However, conclusions from such studies may not always be extrapolated to humans.*

Is the limbic system the "Librium (chlordiazepoxide HCl) system"?

A great deal of experimentation on various animal species suggests that the limbic system is the principal site of action of Librium. Thus, in freely moving cats with electrodes implanted in the brain, Librium 5 mg/kg i.p. slowed electrical activity in the hippocampus, amygdala and septal areas but not in the neocortex which was significantly affected only at higher doses.[1,2] Current investigations on monkeys,[3,4] however, indicate that other subcortical structures may be implicated in the effect of Librium.

Other investigators, through electrophysiologic studies[5] in intact, conscious cats and monkeys, have demonstrated that chlordiazepoxide activates structures involved in the rewarding system—the preoptic area, lateral hypothalamus, septal region and hippocampal formation. At the same time, it appears to *inhibit* structures implicated in aversive behavior—the thalamic nuclei of the diencephalon and the midbrain reticular formation (MRF).

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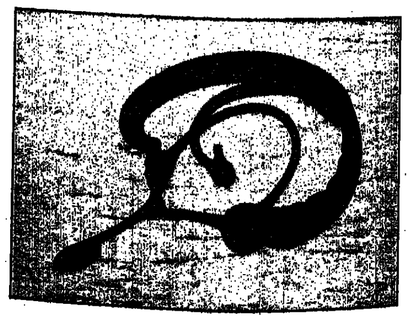
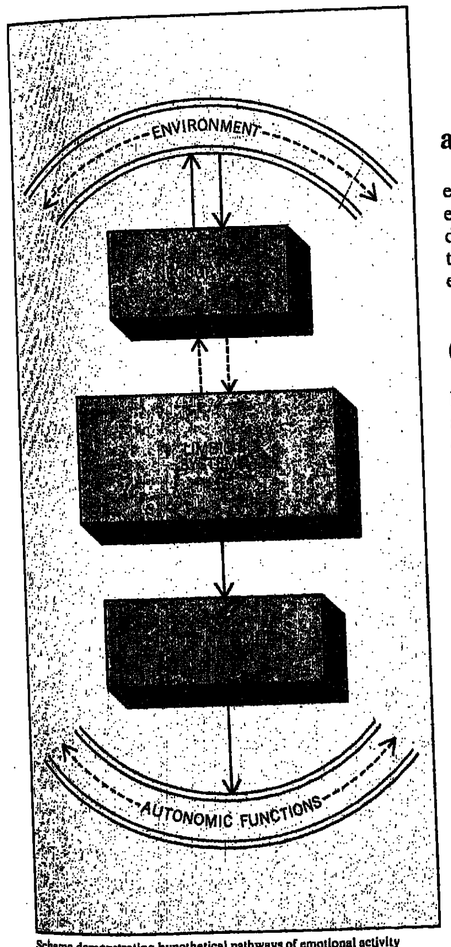




Schema demonstrating hypothetical pathways of emotional activity and its related expression in laboratory animals.

Clinical significance of excessive anxiety

Anxiety, when inappropriate and immoderate, may not only have adverse psychologic effects but may also cause various somatic disturbances. Reduction of excessive anxiety thus contributes to relief of anxiety-linked emotional and physical disorders.

Antianxiety action of Librium (chlordiazepoxide HCl)

The dependable action of Librium has been demonstrated in the relief of excessive anxiety and tension occurring alone or in association with functional and organic disorders—usually without adversely affecting performance. Librium is often used concomitantly, when anxiety is a contributing or complicating factor, with certain specific medications of other classes of drugs, *e.g.*, cardiac glycosides, diuretics and antihypertensives.

Adjunctive use of Librium is recommended when counseling, reassurance or other nonpharmacologic measures alone are not considered sufficiently effective. When anxiety has been reduced to manageable levels, therapy with Librium should be discontinued.

Librium®
(chlordiazepoxide HCl)
5 mg, 10 mg, 25 mg capsules

ROCHE

We're still learning more about it to make it more useful to you.

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation. Increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation; extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Biometric Study Fails to End Diabetes Treatment Dispute

Continued from page 1

example, is Dr. John K. Davidson III of Atlanta, Director of the Diabetes Unit at Emory University School of Medicine. He stopped using oral hypoglycemics at the time that the U.G.D.P. study was announced. In the four-year period since, he said, he has achieved an 80 per cent success rate in the control of diabetes using diet alone. "In fact," he added, "we've found in the four years since we stopped using the oral hypoglycemics that many of our patients didn't require insulin either, and could be controlled by diet alone."

DR. DAVIDSON

Somewhere in between is Dr. Max Ellenberg of New York, who is both clinician and policymaker—he is Clinical Professor of Medicine at Mount Sinai School of Medicine, Attending Physician for Diabetes at Mount Sinai Hospital, and current president of the American Diabetes Association.

"The Biometric Society study hasn't changed a thing," he said, "and there is still every spectrum. And that's the whole problem. There is no unanimity of opinion at all."

However, Dr. Ellenberg added, "even though there was an increased number of deaths attributed to cardiovascular factors, the total mortality was statistically not different from the placebo group. That extrapolation, giving that 10,000 to 15,000 figure [referring to Dr. Thomas C. Chalmers' editorial in the Feb. 10 *Journal of the American Medical Association*] simply has no basis in fact."

DR. ELLENBERG

He said the A.D.A. accepts the study "insofar as it applies to a special group of patients, namely asymptomatic patients, and you cannot extrapolate from this." The increase in cardiovascular mortality seen in the U.G.D.P. study, Dr. Ellenberg continued, "applies to that special group of patients and cannot be extrapolated to the type of patients one treats in clinical medicine, namely, those who have symptoms and have not responded to diet and need further treatment."

The official stance of the A.D.A. Dr. Ellenberg said, is that "the statistics obtained from the special group of patients were inappropriately extended to the use of the drug in all other patients in whom there are indications for its use. These indications are 'symptoms persisting in patients after appropriate dietary therapy has been tried and failed and who are then unwilling or unable to take insulin.'"

Dr. Harold Rifkin, an endocrinologist and Chief of the Division of Diabetes at Montefiore Hospital and Medical Center in the Bronx, said he would treat patients with diet, insulin, or tolbutamide—in that order. He told MEDICAL TRIBUNE he thinks both the U.G.D.P. study and the Biometric Society analysis of it are "first rate." But he added that he thinks a number of other studies should be looked at, too.

And meanwhile, he said, while he would try first to treat patients with diet, or with insulin if diet failed, he thinks there are still definite indications for the oral agents—primarily patients with eye problems or with Parkinsonism who are unable to take insulin.

Yet another approach is voiced by Dr. Henry Dolger, Clinical Professor of Medicine at Mount Sinai. An outspoken critic of the U.G.D.P. study since it first made its report, he said he has "no compunction" about using tolbutamide. In the patient with diabetes of mild to moderate severity, he said, he would first try weight loss. But, he continued, if diet failed he would next try the oral agents, in his clinic population at any rate, because he said he feels the dangers and complications of insulin "are being played way down."

DR. RIFKIN

He said his compliance rate with diet is "less than 15 per cent." In his clinic population, which consists of roughly 1,200 patients, Dr. Dolger continued, about 100 patients are controlled with diet, 400 with insulin, and the remaining 700 with oral agents. In his private practice, the ratio of tolbutamide to insulin patients is reversed. This, he explained, is because private patients referred to him are mostly insulin-dependent, and because he is able to expect a higher degree of compliance and understanding from them. But, Dr. Dolger added, it takes a great deal of effort on the part of the physician, too. He said he is one of the few doctors in New York City who lists his home telephone number and makes his schedule known to his patients.

In the case of the older patient, or the asymptomatic patient, Dr. Dolger said he would use the oral agents in preference to insulin.

While most clinicians interviewed list diet as their first line of attack on diabetes, why are their results with it at such variance?

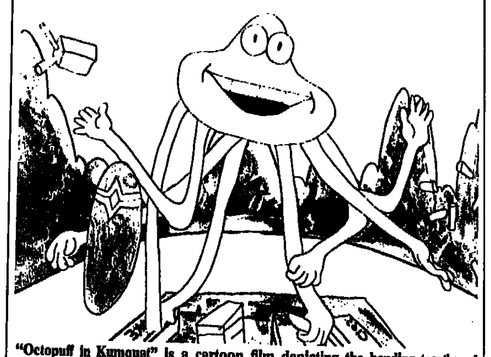
Dr. Davidson attributes his success with it to a "we try harder" approach. "It's not the sort of thing that can be done without a lot of effort. It can be done if the physician is willing to work at it and has doctors and dieticians and nurses to work with him," he said. He estimates that his clinic, which serves about 8,000 patients yearly, has saved $70,000 a year "by not buying the oral agents" and some of this has been put into the team-diet approach. He added that each patient gets about 25 hours a year of diet therapy.

Sees No Substitute for Diet

"The basic problem is simply this," Dr. Davidson added, "if the doctor is going to substitute either insulin or a pill for diet therapy, then he's going to fail. And that's what many physicians in this country have been doing."

Meanwhile, proposed labeling changes for oral hypoglycemics and plans for scientific meetings to discuss these are to be issued "soon, hopefully," according to a spokesman for the Food and Drug Administration.

Romper Room Books 'Octopuff in Kumquat'



"Octopuff in Kumquat" is a cartoon film depicting the banding together of children in the mythical kingdom of Kumquat to rescue their community's lungs and air from the unpleasant effects of smoking. The film, produced by the American Academy of Pediatrics and the American Lung Association, will be shown on "Romper Room" TV programs for the next three months.

Mole Development To Melanoma Held 1:2,500,000 Chance

Medical Tribune Report

NEW ORLEANS—The chances are 2,500,000 to 1 that a mole will not develop into a melanoma, according to Dr. J. Graham Smith, Professor of Dermatology at the Medical College of Georgia.

Dr. Smith told the New Orleans Graduate Medical Assembly that the Melanoma Cooperative Clinical Group estimates there is a total of 4.4 billion nevi in the United States and only 1,750 melanomas develop from these every year.

Dr. Smith noted that only 3 per cent of the population is born with moles, but by the time the average person is 25 years of age, he has 40 of them. At 50 years the average is down to four, and by 80 years nevi are rare.

Danger signs, wherever the nevi are situated, are rapid growth, bleeding, or the showing of a variety of colors—tan, black, red. "Any lesion that shows color should be suspect."

In the removal of a suspect mole, a 5 cm. border should be taken around the lesion.

Dr. Smith quoted Dr. Wallace Clark of Temple University, chairman of the melanoma cooperative group, in suggesting the probable death from metastasis of lesions of varying depth.

If the melanoma invades the papillary dermis, less than 5 per cent of patients die as a result of metastasis. If it fills the papillary dermis, 30 per cent to 40 per cent of patients will develop fatal metastasis. If the invasion is into the deeper side of the recticular dermis, 60 per cent die of metastasis. And if the lesion goes into the fat beneath the skin, 70 to 80 per cent will succumb.

Other members of the cooperative group are Drs. Thomas B. Fitzpatrick and Martin C. Mihm, Jr. of Harvard and Dr. Alfred W. Kopf of New York University.

Precautions Against Contaminants In 'Sterile' Water, Saline Suggested

Medical Tribune Report

NEW YORK—To minimize the risk of infecting patients with contaminants in "sterile" water and saline, hospitals should use the smaller 500 ml. bottles, label them with the patient's name and date of opening, and discard any unused portion after 24 hours, Don G. Brown, Ph.D., told the annual meeting of the American Society of Microbiology, here.

Dr. Brown, who is Director of Environmental Health and Safety at the University of Michigan Hospital in Ann Arbor, based his recommendations on the "alarming" levels of bacterial contamination found in two hundred opened but unemptied bottles of water and saline collected from bedside stands and storeroom cabinets of several midwestern hospitals.

"Approximately one in four (23 per cent) of the saline solutions used for medical treatments contained potential pathogens," he reported. "Fifteen per cent of all distilled water bottles were contaminated." Some of these, he noted, contained up to 10,000 bacteria per ml.

"Among the isolates recovered were Klebsiella pneumoniae, Staphylococcus aureus, and Pseudomonas aeruginosa, all serious pathogens. Sensitivity of the isolates to antibiotics was studied and they were found to be resistant to multiple drugs."

One Man . . . and Medicine

ARTHUR M. SACKLER, M.D.
International Publisher, Medical Tribune

The following column was not published before because of two reasons; the first was that it would have been deemed political at an earlier date, and the second was that Medical Tribune has never published a scoop if it related the details of Grand Jury proceedings or a trial in progress.

Today, neither factor is operative. It may read as a sad historic comment on a past period of national psychic aberration. *A.M.S.*

The Time Capsule

and the Devil's Advocate

"ANYONE WHO OPPOSES US WE'LL DESTROY. As a matter of fact, anyone who doesn't support us we'll destroy."

So spoke a former member of the White House staff to a nationally recognized psychiatrist who was not prepared to "go along" with the White House staff.

I never had a chance to interview the young man. Those who know him say he is a "nice" guy, attractive, well educated, smart. They also say, "when the going gets tough, the tough get going." Could he "tough it out"? This was early-on in the game plan. Later he had to choose from several options. True, he wasted one, the "not to the best of my recollection" option. He actually recalled his not-so-elegant phraseology. But he had other options. He could point to the unsettled medical state of the land—students protesting an escalating medical curriculum, physicians restless with Washington regulations of medical practice, some medical organizations in rebellion against "Big Brother's" interventions in medicine. He could also opt for "I was just playing devil's advocate."

Via the Time Capsule

In this time frame, I climbed into my time capsule to go back in time and space. After landing on the outskirts of Moscow, I took the road which now leads from Sheremetyevo Airport to the center of the city. I checked into the Rossiya Hotel, contacted the foreign ministry and was told that my appointment with Joseph Stalin was the next evening at 6:00.

Stalin's work habits were such that he was up most of the night and slept in the morning. As I walked across from the hotel to Red Square, the lines I had seen earlier in the day at Lenin's Tomb were no longer there. The crenelated towers of the Kremlin and the bulbous onion-like tops of St. Basil stood out against the backdrop of a blood-red sunset. I was finally ushered into The Presence. The man seated behind the green covered table was short and stocky; a pock-marked face, piercing eyes. He had a close crew cut and a commanding figure. I went straight to the point.

"Mr. Stalin, Sir, about the ropes that were found at the Katyn mass graves. It has been said that hundreds were left to hang there to twist slowly, slowly in the wind."

"That's my metaphor," he responded. "The implications are bourgeois democratic party propaganda. Those were not graves, they were pits in which the Nazis kept slave labor prisoners. The ropes were part of our efforts to hoist these poor victims to freedom."

"But why were they found buried in mass graves, Sir?"

"Their rations were small, their labor hard, their strength exhausted. They tried to climb up our ropes to a better world. Their strength was gone. They slipped and fell and hung, twisting slowly, slowly in the wind."

"But why the mass graves?"

"That was the humane and decent thing to do."

"Mr. Stalin, Sir, when President Jan Masaryk was found dead outside the window of his office, it was reported that instead of being thrown out the door, he was thrown out the window. Would you care to comment on that, Sir?"

"That is a lie, a leak to the partisan press, just bourgeois democratic party propaganda. Actually, Masaryk said the room was stuffy, mistook window for door, and before our people could save him he fell and broke his neck."

"Pardon me, Sir, Mr. Stalin, considering the world-wide incidence of the severe psychoses, you seem to have a very high population in your psychiatric hospitals."

He responded quickly. "National security," he said.

On the way back to my time capsule as I thought of what I had just heard, a phrase kept reverberating in my brain. It sounded like, "That just doesn't seem to track . . . doesn't seem to track."

When I returned to the States, despite my eerie feeling that there could be a cover-up, I published my scoop. I was attacked as unbelieveable, my patriotism challenged, and I was accused of spreading subversive propaganda.

Another Trip

Some months later, undaunted, I once again climbed into my time capsule and flew back in time and space to Berlin. After landing at Tempelhof, I dropped my luggage at Hotel Kempinski, caught a taxi on the Kurfurstendamm and went directly to the Chancellory. I also went directly to the point.

"Führer," I asked, "were your assistant, Roehm [SA Chief of Staff] and some of his friends lined up on a lawn and shot?"

"By the glory of our thousand year Reich, that is a damnable lie. He was against suicide; he offered to stand on a street corner. I said no. I embraced my comrade from the Munich days and the putsch and as he turned from my embrace he accidentally tripped and fell on a honor guard's gun. He wasn't shot. It would have been simpler to take him out on the lawn and give him a lecture."

"Führer, Sir, there are newspaper stories as to how the mentally unfit are being sterilized and the Jewish problem is being solved, that there are concentration camps, gas chambers and human ovens."

"More liberal lies, more polluted political press propaganda, more democratic dirty tricks."

"One last question, Führer, Sir. What happened to over six million men, women and children . . ."

"There is no need to know."

On my way back to Templehof, another damned refrain reverberated in my brain, "Those stories don't seem to wash, don't seem to wash . . ."

Well, despite my growing puzzlement, I filed my story. This report, too, created a great fuss. "Once you've seen one dictator, you've seen them all," some critics said. I was labelled an irresponsible member of the anti-liberal establishment press. I was accused of rushing into instantaneous analysis. I was hurt and left to, uh, "bleed for a while."

Catching Up With Time

"At this point in time" I began to feel that maybe I had misread the scenario, that those political pranks and cover-ups might be more serious than a few dirty Dick Tuck tricks. I decided to come clean. I went to see my lawyer, rendered my prior reports "inoperative," and smashed my time capsule. Since then I've developed strong protective reactions and I've learned how to maintain neutrality by "tilting" in the right direction.

* * *

As for the young man's option—you know the "devil's advocate" one. I can't buy that.

When I smell sulfur—that isn't the Devil's Advocate—that's the Devil himself!

Medicine on Stamps

Frederick Jean Joliet-Curie

Born in Paris in 1900, he received his doctorate from the University of Paris. Becoming assistant to Marie Curie, he married her daughter Irene, a physicist in her own right. In 1934 they prepared the first artificial radioisotopes by bombarding aluminum with alpha particles of helium nuclei. Neutrons and positively charged particles were emitted. Their work, earning them the Nobel Prize in Physics in 1935, laid the foundation for the diagnosis and treatment of many diseases by isotopes.

Text: Dr. Joseph Kler
Stamp: Minkus Publications, Inc., New York

EPIGRAMS—Clinical and Otherwise

A man is as old as his arteries.
Thomas Sydenham (1624-89)

New Data on Transmissibility Of Crohn's Disease Offered

By JOSEPH HIXSON
Special Tribune Correspondent

ATLANTIC CITY, N.J.—Additional evidence for the transmissibility of Crohn's disease and further hints of its viral etiology were presented by Dr. Donald N. Mitchell's group of St. George's Hospital, London, at the recent meeting of the American Federation for Clinical Research.

It was Dr. Mitchell and Dr. R. J. Rees who first reported in 1970 that homogenates from the ileum of Crohn's patients would produce granulomas in the footpads of mice. In 1973, Dr. Mitchell, Dr. David Cave, and Dr. Bryan Brooke reported in *Lancet* that they had produced fibrous plaques, abscesses and granuloma in the ilea of rabbits by infiltrating the animals' guts with material from patients with ileitis and claimed they had a good animal model of Crohn's disease.

Here, Dr. Cave reported that material taken from four of six patients has not only produced the granuloma in white New Zealand rabbits, but that lymph nodes from these animals can produce the disease in other rabbits. He also said that the disease passage could be achieved even after the suspended homogenate was passed through 100 or 0.2 micron filters.

Coincident with the Mitchell group's first *Lancet* report on the rabbit ileal disease, investigators from the Welsh National School of Medicine said they had not been able to initiate any lesions in immunologically suppressed rats, mice or guinea pigs. Other researchers also published papers saying that they could not duplicate Dr. Mitchell's findings. But at last year's meeting of the Association of American Physicians, Dr. Henry Janowitz and colleagues at Mt. Sinai Hospital in New York declared that they, too, had produced invasive granulomas in the mouse footpad using material both from the intestines and mesenteric lymph nodes of patients with Crohn's disease.

The rabbit lesions take considerable time to develop, Dr. Cave reported, often requiring ten or eleven months before they are distinctly observed at biopsy or autopsy.

Four Studies Show Day Care Causes Children No Harm

BY PATRICIA MCBROOM
Special Tribune Correspondent

PHILADELPHIA—Day care has no harmful effects on the intellectual or emotional development of children reared for many hours a day outside the home, according to four United States studies of nearly 200 infants and toddlers.

Across the board, the children in day care were as well developed as middle class children raised at home, and they actually performed better than did lower class children from poor homes.

The studies all set out to test the hypothesis that day care has deleterious effects. "But they couldn't prove it," said Kuno Beller, Ph.D., a Temple University psychologist who spoke at a recent seminar on day care held at the Medical College of Pennsylvania.

"Any statement now that day care is bad is just as erroneous as the statement that parenting is good. There are good and bad day care centers, just as there are good and bad parents."

The research cited by Dr. Beller has been completed in the last five years at State University of New York at Syracuse, University of North Carolina, Greensboro, Ontario, Canada, and Harvard University. There were never more than 10 children to a group, with a child-adult ratio of three to one. For toddlers, it was usually four to one.

Attention Is Multiplied

The intellectual stimulation given was "no less than would be available in a good middle class home," said Dr. Beller. In fact, the children easily received "five times as much attention" as they would have gotten at home with busy mothers. "In day care, the adults have nothing to do but attend to the children," said Dr. Beller.

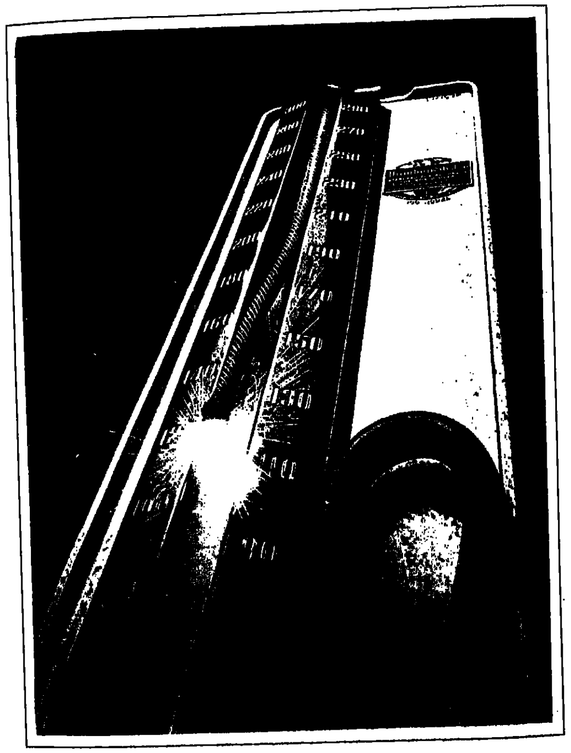
The seminar, cosponsored by the Pennsylvania chapter of the American Academy of Pediatrics, and M.C.P.'s Center for Women in Medicine, was stimulated in part by the childcare problems of women physicians.

"We've come to realize that the availability of child care influences the education and practice of women physicians," explained Dr. Nina Woodside, director of the Center. "Women need options. There is a great need to develop day care both inside and outside the home."

Dr. Beller added that many mothers in medical school feel guilty about not being at home. But, he said, "with the emancipation of women, day care is here to stay, period. Anyone making people feel guilty is doing a disservice to society."

Dr. Susan Aronson, Professor of Pediatrics at M.C.P., spelled out the need for day care in terms of national statistics. According to the Senate Finance Committee, there were 10,500,000 working mothers in the United States in 1973. Roughly a third of mothers with children under six were in the labor force, rising to more than half of mothers with children aged 6 to 17.

"The question is no longer whether there will be child care, but what form it will take," said Dr. Aronson.



Tribune Economic Analysis

NY State Urged To Use Formula Of Ex-Im Bank

BY ELIOT JANEWAY
Consulting Economist

Past generations of financial reformers found themselves pioneering by guess and by feel. Today's problem of channeling capital funds to borrowers favored by public policy without wrecking the credit structure is easy to solve.

The way to do it is to make the Ex-Im Bank formula domestic.

I made a proposal to do just this in response to an invitation from New York State Assembly Speaker Stanley Steingut. He is sponsoring legislation that would create a New York State bank. My testimony focused on the Ex-Im Bank as the practical model for New York to adopt in adding the new dimension to the banking system that it needs.

The Ex-Im Bank Formula

The Ex-Im Bank's formula is simple and workable. It calls for a 10 per cent commitment by the borrower, a 45 per cent uninsured commitment by the lending banks and a federally insured call by the banks on the Ex-Im Bank for the remaining 45 per cent of the approved loan advanced. The borrowers pay the cost of the insurance premium provided by the Ex-Im Bank.

My proposal calling for the formation of a New York State version of the Ex-Im Bank would reactivate the commercial and savings banks of the state to help them cope with the troublesome blockages that have developed in the way of mortgage and municipal finance. It would give the banking system of New York State an overdue opportunity to enjoy the benefits that the Ex-Im Bank has been enabling the country's banking system to provide for the benefit of the American economy's export customers.

The eyes of the financial world are trained on New York. Justice Brandeis' concept of the states as "the laboratories of change" is coming into its own. The idea of mobilizing state deposits as ammunition aimed at social targets is an attractive one, and it will travel.

Is the depression caused by the collapse of the Vietnam war? Wouldn't production of war materials revive the economy? Or are we already producing war materials and still in a depression?
Dr WW II Vintage

Your vintage dates your point of view. Today's military technology gives us enormously bigger bangs for tonnages and materials and hours of labor so small in proportion to the bang that they're scarcely worth talking about. Read my *Economics of Crisis* to understand how the escalation of the War in 1968 hurt the economy and how subsequently de-escalation helped it. Providentially, another war is not in the cards, but if it were, we could go right on suffering a slump through it.

70 Viet Doctors Seek Help in Becoming Part of US System

Medical Tribune Report

FT. CHAFFEE, ARK.—Seventy South Vietnamese physicians who were forced to leave their homes and practices in the wake of the communist take-over are making a plea to American doctors for help in becoming part of the United States medical system.

The doctors—now housed here in Army barracks along with 19,000 other Vietnamese refugees—told MEDICAL TRIBUNE they are lost in a strange country with no funds, no work, and at this point, a doubtful future.

"Many of us are without any money and have to depend solely on what is given to us," said Dr. Lam Van Thach, former Chief of Vietnam's Center for Rehabilitation Medicine in Saigon.

"We had to leave in a hurry—some with as little as 12 hours notice. We have lost our homes, positions, and everything else we couldn't carry by hand," he said.

Calling their plight "very uncertain," the physicians said they are hoping the special help they need will come from the U.S. medical community.

Must Pass ECFMG Test

According to H.E.W. the physicians will not be allowed to practice in this country until they pass the E.C.F.M.G. test—now required for all foreign medical graduates —and the medical licensing board of the state in which they plan to work.

"I suppose we are caught between the devil and the deep blue sea," Dr. Thach said, explaining that many of his colleagues might not be able to take the E.C.F.M.G. for several years.

"Most of us came here with little or no money at all. It will be impossible for those with no funds to jump right in and learn English, go back to school to pick up whatever is required before we can work, and support our families all at the same time.

"We are not asking for handouts," Dr. Thach explained, "Only some help in getting direction, and perhaps educational assistance in the form of scholarships to help those with no funds meet the qualifications necessary to practice in the U.S.

"It must be remembered," he added, "that medical schools in Vietnam are patterned after the French system, and most of these physicians have as much as 21 years invested in medical school, intern and residency programs."

Echoing feelings of despair and bewilderment, Dr. Buu Chau, Chairman of the Department of Community Medicine at Waay Medical School before fleeing Vietnam, said he and his colleagues are in a unique situation.

Only a Few Speak English

"A few of us speak English, but the others don't. If we do not receive special help—and we will need it because our situation is not the same as other refugees when it comes to starting a new life here in the U.S.—then there is little we can do. We just do not see how we can study for the E.C.F.M.G., learn a new language, and at the same time go out and get whatever job we can find to support our families," Dr. Chau said.

The question of sponsors—American citizens willing to accept responsibility for one or more refugees—is also uppermost in the minds of many refugee physicians.

"Only two or three have sponsors at this point, and of course, each of us must have a sponsor before we can even get started," Dr. Chau said. "Ideally, we would like to be sponsored by physicians, someone who could give us the necessary direction while we are filtering into the system.

"We cannot get out of here until we get sponsors. Even those that left Vietnam with enough funds to live on for a while cannot leave until they have a sponsor," he added.

Despite the inconveniences of refugee life, such as entire families living in wooden barracks' with plywood walls and linen doors, the Vietnamese physicians have lost no time organizing their ranks and plotting to begin a new life in a strange country.

Using a small abandoned building, the doctors have set up an information center for Vietnamese health care workers, including physicians, dentists and nurses, to keep them posted on their status.

Dr. Chau hastened to add that members of the Arkansas State Medical Society have contacted the Vietnamese physicians and are doing what they can to coordinate activities between the refugee doctors and the proper authorities.

"As things now stand," Dr. Chau said, "We cannot practice at all—not even here in the refugee camp. All we can do is wait and hope we get the help we need."

More than 18,000 refugees are quartered at Camp Pendleton in California, swamping the base's medical facilities. An appeal among the refugees for help brought more than 80 doctors to work on a volunteer basis. Although not allowed to practice, they can give first aid and perform other paramedical services.

Vitamin D Excess Seen Adding to Atherosclerosis Risk

By FRANCES GOODNIGHT
Medical Tribune Staff

ATLANTIC CITY, N. J.—The possibility that vitamin D in excessive amounts can add to the risk of developing atherosclerosis was suggested here at the annual meeting of the Federation of American Societies for Experimental Biology.

Fred A. Kummerow, Ph.D., of the University of Illinois, described experiments on swine which indicated that the aortas of animals fed a basal fat-free ration supplemented with extra vitamin D_3, plus fat and cholesterol, showed a higher percentage of degenerative smooth muscle cells than did the aortas of swine fed the basal ration with no further supplement or with vitamin D_3 as the only supplement.

Cell degeneration (on the basis of total cell counts) was 7.96 per cent in the animals getting the three supplements; 5.6 per cent when the basal ration was unsupplemented; and 7.43 per cent when only vitamin D_3 was added.

Dr. Kummerow said another finding of the studies—conducted by the Illinois group in cooperation with investigators at Albany Medical College and the Food and Drug Administration—was that some human beings on "normal" diets had higher vitamin D levels in their tissues than the levels assayed in swine fed a regular commercial ration.

A typical commercial swine ration contains 780 I.U. of vitamin D_3 per pound or about 14 times the National Research Council recommendation for swine feed, he pointed out, since the animals are usually raised in confinement today and require the vitamin supplement for optimum growth. Rations of other livestock similarly raised also contain greater than recommended amounts of vitamin D, and the investigator noted that the vitamin is present in resulting edible meats, chicken, etc.

Tissue Levels in Swine

Tissues from swine on a regular commercial ration had 360 I.U. of vitamin D per pound of muscle (525 per pound of heart tissue), 600 per pound of liver, and 380 per pound of fat, Dr. Kummerow said. The level in serum was assayed at 386 I.U. per 100 ml.

These figures, however, were lower than the tissue vitamin D levels in some human subjects—454 I.U. per pound of muscle, a range from zero to 1,860 per pound of liver, 544 to 1,770 per pound of fat, and 500 to 1,800 per 100 ml. of serum.

Muscle tissue from a patient treated with vitamin D_3 for osteomalacia assayed for three times more vitamin D than comparable tissue from swine fed 100,000 I.U. of vitamin D_3 per pound of ration for five weeks, according to Dr. Kummerow.

When the investigators studied the effect of fat and/or vitamin D on in vitro synthesis of cholesterol from 1-14C acetate in liver tissue, they found that liver tissue from swine fed a basal diet plus fat and vitamin D_3 synthesized 2.37 nanomoles of cholesterol per 100 mg. of tissue in a two-hour incubation period.

Comparable figures were 1.35 nanomoles synthesized by liver tissue from animals fed a basal ration, and 1.68 nanomoles synthesized by liver tissue from swine fed the basal diet plus fat.

A similar trend was noted in the synthesis of cholesterol in adipose tissue, but no increase was observed in fatty acid synthesis.

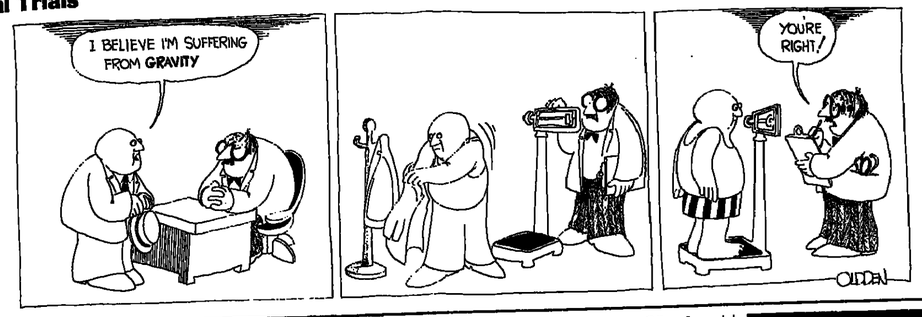
Dr. Kummerow commented that an increase in serum cholesterol in swine fed vitamin D plus fat or a source of cholesterol seemed to occur in the cholesterol ester rather than free cholesterol.

Role in Ester Synthesis?

"It is possible that vitamin D may be involved in some regulatory process governing the synthesis of cholesterol ester," he said, "and the increased cellular concentration of cholesterol esters may accelerate the degeneration of smooth muscle cells."

The fact that heart tissue proved to have an even higher vitamin D level than ordinary muscle tissue in swine fed a commercial ration could be important, in his view. If vitamin D accelerates cholesterol ester synthesis in heart tissue, "it may contribute to the more rapid accumulation of cholesterol esters in the coronary arteries."

Clinical Trials by Oldden



TRIBUNE SPORTS REPORT

Negligence Claims on Rise, Team Doctors Are Warned

Medical Tribune Report

WASHINGTON—Dr. A. A. Savastano, Clinical Professor of Orthopaedic Surgery at Brown University, warned here that negligence claims against school officials, coaches, trainers, and physicians "are on the increase."

"Those who are serving as team physicians will do very well to take every precaution to avoid becoming directly involved as defendants in tort liability cases," he told a sports-medicine symposium at Georgetown University School of Medicine.

The A.M.A. Committee on the Medical Aspect of Sports, he noted, has stated that whether a team physician is a consultant working for a college or university or is a volunteer in a secondary-school program, he faces a dual responsibility of ensuring:

- "That the athlete is not deprived unnecessarily of the opportunity to participate if an injury or other clinical condition is not potentially serious and does not interfere with the player's performance; and, conversely,
- "That the student's future in athletics and in life is not jeopardized by unwarranted eligibility for a particular sport or by premature return to competition in any sport after illness or injury."

If the physician conforms to the standards of good medical practice in his community, Dr. Savastano said, "there is no reason why medical supervision of any athletic team entails risks of legal liability any greater than in any other area of medical practice."

Other Cautions

He did, however, add the following cautions:

- The physician should avoid giving any guarantee that it would be safe for a candidate to participate in a given sport.
- The physician should not undertake medical treatment without the parents' prior consent, express or implied, except for first aid or emergency care that is reasonably necessary to save life or limb.

Dr. Savastano also warned the team physician not to accept waivers signed by parents in cases where he finds disqualifying physical defects in a young athlete.

"Generally speaking," he said, "the parent has no authority to release future claims on behalf of the child. It is to be remembered that the statute of limitations does not begin until the child has become of age."

If the youngster is permitted to participate in a sport against medical advice, the physician should again make his position clear, in writing, to parents and coaches, Dr. Savastano said.

Negligent Inaction

Noting that charges of negligence can result from inaction, he cited an instance in which a young quarterback was injured during a preseason high-school football scrimmage. After the coach ascertained that the boy was still able to grip with his hands, the youngster was carried off the field by eight other players, allegedly without anyone ordering the move. There was conflicting testimony as to whether the physician who was present had examined the boy before he was moved. The only undisputed testimony was that the boy is now a quadriplegic.

The medical witness' opinion, Dr. Savastano said, was that the injury to the boy's spinal cord occurred while he was being carried from the field without the use of a stretcher.

Awarding judgment of $206,804 plus costs against the coach and the physician, the court declared that both had been negligent—"the coach for failing to wait for the doctor and allowing the plaintiff to be moved, and the doctor for failing to act promptly after the plaintiff's injury."

Actionable Situations

Dr. Savastano listed the following situations that could result in action against the team physician:

Failure to recognize an injury.

Certification of a participant with known limitations for a sport.

Premature termination of treatment.

Failure to follow up a case under treatment, as this may be construed as abandonment of treatment. (When athletes terminate treatment before they are medically discharged, it would be wise for the physician to make a serious attempt to get them to resume treatment.)

Failure to refer to qualified specialists for consultation.

Failure to explain preoperatively to both the parents and the injured any surgical procedures anticipated and the possible end results of this surgery.

Promises of full, excellent, or good recovery for any specific case.

Inadequate recovery in a case in which a new treatment has been tried without explanation.

Failure to obtain x-rays of an area of trauma.

Failure to check a cast after its application for abnormal constriction or compression.

Failure to administer antitetanus drugs where indicated.

Failure to administer antibiotics where indicated.

Failure to elicit allergic history before prescribing medication.

'Spirit Makes a Man'

Dr. Joseph J. Panzarella, Jr., a specialist in rehabilitation and himself a quadriplegic, recently received Dr. Frank L. Babbott Memorial Award for distinguished service to his community and to medicine at the Downstate Medical Center alumni reunion. Dr. Howard Rusk once described Dr. Panzarella as "the best example I know of the philosophy that arms and legs and eyes and ears don't make a man; spirit makes a man."

IMMATERIA MEDICA

Naked Came The Sexless Chicken

Back in March we reported on the development of the featherless or naked chicken, which in our opinion isn't a chicken if it has no feathers. But we never expected to be getting the latest dope on the naked chicken from the *Wall Street Journal*, but that's how hard up for good news they are down there.

Wall Street Journal reporter David Brand visited the poultry research laboratory at the University of Connecticut at Storrs and he came back with the awful truth. It seems that naked birds, "bereft of wing and tail feathers" in Mr. Brand's phrase, can't mate because they can't achieve the necessary bird-to-bird balance. Thus reproduction is by artificial insemination.

Aware of man's own featherlessness, we thought about that a long time. What a difference a few feathers might make for all of us.

In our earlier report, we asked if somebody couldn't come up with a proper scientific name for these non-chickens. We rather like what Mr. Brand called them: "pre-plucked." It's the kind of term his Wall Street readers would understand.

Vacation Obsolescence

Discussing the good prospects of Foster-Grant, the sunglass makers recently taken over by his company, American Hoechst president John G. Brookhuis said: "People are vacationing in spite of business conditions and when they do they always buy sunglasses. Like everyone else, my dear wife, always needs a new pair because she always manages somehow to sit on them while on vacation . . ."

What Next Dept.

WASHINGTON—(UPI) The freckelbelly madtom catfish, the Rustyside sucker and the blind cavefish are dwindling in numbers, and the interior department wants to determine if they should be declared endangered species.

There are 26 other fish on the list of species the department said it would investigate.

Would emdees qualify as an endangered species?